or the interim rates as established by the Medicare intermediary until the submission of actual costs. At the end of each Home Health Agency's fiscal year end, an actual cost report must be submitted which is used for the purpose of completing a cost settlement based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits.

B. Durable Medical Equipment is equipment or supplies provided by a contracted Durable Medical Equipment (DME) provider that is to remain at the Medicaid client's home or is to be used by a Medicaid recipient who resides at home. Reimbursement is based on the lesser of billed charges, State Agency determined allowable fees, or the Medicare prevailing charge(50% percentile).

9. Clinical Services:

Payment will be made according to an established fee schedule and will not exceed the allowable payment established for those services by Medicare (Title XVIII).

10. Dental Services:

Reimbursement to providers of dental services is made on the basis of an established fee schedule not to exceed prevailing charges in the state. Reimbursement will be provided on a per procedure basis. The current reimbursement rates are based on the 75th percentile of usual and customary reimbursement. This percentile was determined by an independent company's analysis of all dental claims filed in the state within a calender year. The revised payment rates are approximately 325% above the preceding rates.

11.a. Physical Therapy/Occupational Therapy:
&
11.b. Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 4-19-B, Page 2a. All requirements identified under 42 CFR 447.200ff and 447.300ff shall be met.

11.c. Speech/Language and Audiological Services:

Payment will be according to an established fee schedule.

12.a. Prescribed Drugs:

Medicaid pays for FDA approved prescribed drugs with stated exceptions described in Attachment 3.1-A, Item 12-A, Limitation Supplement.

1. Basis for Payment:

A. MULTIPLE SOURCE DRUGS

Reimbursement for covered multiple-source drugs in the Medicaid program shall be limited to the lowest of:

(1) The Federally-mandated upper limit of payment or South Carolina Maximum Allowable Costs (SCMAC), for the drug less the current discount rate (13%), plus the current dispensing fee; or

(2)The South Carolina Estimated Acquisition Cost (SCEAC) which is the average wholesale price (AWP) less the current discount rate (13%), plus the current dispensing fee; or

(3) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

B. OTHER DRUGS

Reimbursement for covered drugs other than the multiple-source drugs with HCFA upper limits shall not exceed the lower of:

(1) The South Carolina Estimated Acquisition Cost (SCEAC), which is the average wholesale price (AWP), less the current discount rate (13%), plus the current dispensing fee; or

(2) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

C. PRODUCTS WITHOUT AN AWP WHOSE PRICE INCLUDES OTHER SERVICES

For pharmaceutical products having no AWP and whose billing price includes services other than ingredient cost, the state will impute its EAC based on available data. Final reimbursement is based on the imputed EAC plus the current dispensing fee. Only the provider actually rendering the service can be reimbursed; however, in cases where a single payment is made for several medically necessary services provided by one entity, the state will allocate the components of the payment to the particular Medicaid benefit with which they are associated.

D. ALTERNATE REIMBURSEMENT METHODOLOGY (ARM)

A provider of pharmaceutical services to long term care facilities may opt to be reimbursed under the Alternate Reimbursement Methodology (ARM).

The ARM rate is based on historical reimbursement and utilization data for prescriptions of residents of long term care facilities. Reimbursement to the provider is based on the established rate times the estimated patient day totals for those recipients served by the contracted provider. Adjustment of the reimbursement is made when a comparison of the estimated versus actual patient days for the month yields a difference. The ARM rate will not exceed the upper limits of payments under the non long term care reimbursement methodology described in this section.

2. DEFINITIONS:

A. UPPER LIMITS OF PAYMENT (42 CFR 447.331)

The upper limit of payment for certain multiple source drugs is the amount designated by HCFA or the South Carolina program - whichever is less. Payment for these drugs, in the aggregate, cannot exceed those limits set by HCFA.

B. SOUTH CAROLINA ESTIMATED ACQUISITION COST (SCEAC)

SCEAC is defined as the State's closest estimate to the price generally and currently paid by providers for specific drugs, based on the package size of drugs most frequently purchased by providers. EAC established by South Carolina is the AWP (Average Wholesale Price) minus 13%. The AWP used in calculating the SCEAC is furnished by a contracted pricing source.

3. MULTIPLE SOURCE DRUG REIMBURSEMENT LIMITATION/PHYSICIAN OVERRIDE

A physician may prescribe a brand name of a multiple source drug that bears a higher cost than the upper limit established by HCFA or South Carolina but reimbursement is available only if the prescription has the physician's certification (in his own handwriting) that the specific brand is medically necessary for a patient.

4. CO-PAYMENT FOR PRESCRIPTIONS:

There is a standard co-payment of $2.00 per prescription (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Prescriptions filled by dispensing physicians are not subject to co-payment.

5. DISPENSING FEE:

Dispensing fees are determined on the basis of surveys that are conducted periodically and take into consideration pharmacy operational costs (overhead, professional services, and profit in different types of pharmacies).

The current dispensing fee is $4.05 for independent pharmacy providers; $3.15 for institutional pharmacy providers; no dispensing fee for dispensing physicians.

Dispensing fees are paid to the following type providers:

"Free-Standing" contracting pharmacies not otherwise reimbursed by Medicaid for other services on a cost basis.

"In-House" pharmacies reimbursed by Medicaid on a cost basis for other services.

Dispensing physicians are reimbursed only for the cost of the drug.

Additional Upper Limit Application:

The upper limits as described in this Attachment Section also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, HMO or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribing drugs.

12.c Prosthetic Devices and Medical Supplies, Equipment and Services:

Certain medical services, supplies, and equipment (including equipment servicing) that do not generally vary significantly in quantity will be reimbursed at a rate not to exceed the rate established by the Medicare carrier in the area at the lowest charge level at which the services, supplies, and equipment are widely and consistently available within their locality according to the procedures prescribed in 42 CFR 405.511. A list of these items of sevice is published in the federal regulations. This upper limit is applicable to such services furnished under both Medicare and Medicaid.

For selected services and items furnished only under Medicaid (and identified and published by the Secretary of HHS by regulation), the Medicaid agency must calculate the lowest charge levels under the procedures specified in 42 CFR 405.511(c) and (d), and limit payments to that amount.

Hearing Aids - Prices are established via competitive bidding, conducted by the S.C. General Services Agency. Hearing aids are provided through the Division of Crippled Children's Care, Department of Health and Environmental Control (DHEC).

Home Dialysis - Reimbursement for equipment and supplies are included in the all inclusive rate paid only to the End Stage Renal Dialysis Clinic.

12.d Eyeglasses:

Services are provided under a sole source contract. Reimbursement is based on competitive bid. The duration of the contract is one year.

13.c Preventive Services

Family support services provided as a preventive service under this section must be provided by a physician or other licensed practitioner of the healing arts as required by 42 CFR 440.130(c). The following services will be reimbursed by Medicaid as a family support service provided as a preventive service:

(A) - Individual family support services provided by a professional (unit of service - 15 minutes)
(B) - Group family support services provided by a professional (unit of service - 15 minutes)
(C) - Assessment provided by a professional(unit of service - 15 minutes)

Medicaid reimbursement rates for family support services provided as a preventive service will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for family support services is defined as fifteen (15) minutes of service delivery.

Providers of family support services as a preventive service will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers actual unit cost or the maximum rate that has been established.

13.d Rehabilitative Services

Reimbursement is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable service under comparable circumstances. With public agencies the provider fee will not exceed the actual cost for the delivered service.

Rehabilitative Services for Primary Care Enhancement as defined in 3.1-A, pages 6c and 6d, paragraphs 13d. A, B, C and D may be provided by a physician or other licensed practitioner of the healing arts, or under the direction of a physician or other licensed practitioner of the healing arts as permitted by 42 CFR 440.130(d). The following services will be reimbursed by Medicaid as a rehabilitative service for Primary Care Enhancement:

(A) - Individual rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)
(B) - Group rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)
(C) - Assessment provided by a professional (unit of service - 15 minutes)

Medicaid reimbursement rates for rehabilitative services for Primary Care Enhancement will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. The rates will represent composite rates, in that professional and paraprofessional costs will be combined in order to establish one rate for each service. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for rehabilitative services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.

All providers (i.e., private and public) of rehabilitative services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers actual unit cost or the maximum rate that has been established.

17. Nurse Midwife Services:

Self-employed - Reimbursement is calculated at 80% of the current physician allowable amount for the delivery and 100% of the current physician allowable amount.

Employed - Reimbursement is calculated at 100% of the current physician allowable amount.

18. Hospice Services:

With the exception of payment for physicians services reimbursement for hospice services is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The rate is no lower than the rates used under Part A of Title XVIII Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the individual.

The four reimbursement rates are applicable to the type and intensity of the services (level of care) furnished to the individual for that day. The four levels of care into which each day of care is classified are:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

For continuous home care, the amount of payment is determined based on the number of hours of care furnished to the patient on that day.

Limitations on Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. The requirements found in 42 CFR 418.302(f)(1)-(5) will be imposed when implementing the limitations on inpatient care.

associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment to private providers will not exceed the established statewide average cost for the service.

20.A & B Extended pregnancy related services are reimbursed individually at an established fee-for-service rate. All service rates are based on a statewide average cost for the service. Services rendered by public agencies will not exceed cost as required in 42 CFR 447.321 or 42 CFR 447.325.

24. Transportation: (Effective 3-10-87)

Ambulance: Payment for ambulance services will be the lesser of actual charges submitted by the carrier or the ceiling of the fees established by DHHS. The fee schedule will be applied uniformly without consideration of locality. In the aggregate, fees do not exceed Medicare (Title XVIII) reimbursement for the same service.

Other type of transportation: Reimbursement for other types of transportation not available free of charge is made on the following basis.

- Transportation provided by a common carrier at actual cost.
- Negotiated agreement on a cost per mile basis with organizations providing such services.
- Transportation by volunteers at a traveled fixed rate per mile.
- Transportation by taxi with a negotiated agreement on a fixed rate per mile.

24.g Birthing Center: Payment will be made at an all inclusive facility rate according to an established fee schedule.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item 24. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part A Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) ___.

Lucia 4/3/89